

## DENTAL FINANCIAL POLICY

We realize that every person's financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care you need and want with respect to your budget. Also due to the new HIPPA regulations, it is important that you know your dental benefits and coverage in detail as the insurance companies don't disclose all information to us.

### Dental Insurance

As a courtesy, we will be happy to submit the dental claims necessary to see that you receive the full benefits of your coverage; however we cannot guarantee exact estimated coverage. Because your insurance policy is an agreement between you and your insurance company, we ask that all patients be directly responsible for their portion at time of service. Please know that we will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company has not paid their portion within a reasonable amount of time, you are responsible for the remaining balance.

### Payment Options

- Cash or Check (5% discount with payment in full at time of service, cash or check only)
- Per Visit Arrangement: (CROWNS ONLY) You pay ½ of your portion on prep appt. and the remaining ½ on seat appt. (NOTE, the 5% discount will not apply)
  - Credit Cards: We accept Mastercard, Visa, and Discover.

### Care Credit

We are aware that unexpected dental care costs can significantly impact your budget and we want to make our services as affordable as possible. For this reason we have adopted CareCredit as our office monthly payment plan.

- CareCredit offers many benefits for you and your family including an interest free option. Get all the treatment you need now and pay for it over an extended period of time.
- Our staff will assist you in applying for CareCredit. A credit line can be established and approval usually takes less than 10 minutes.
- CareCredit is a revolving credit arrangement. You will receive a CareCredit Card that can be used to finance past balances, today's costs and future costs for any dental care received.

### Missed Appointments

*Your appointment time is reserved only for you. If you must reschedule, we ask that 24 hours notice be given. For all missed appointments without 24 hours notice, a \$25.00 fee will be applied.*

Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

# Richard C. Downing, D.D.S.

1626 Olympic Highway North

Shelton, WA 98584

## HIPPA PATIENT CONSENT FORM

I understand that I have a right to privacy regarding my protected health information. These rights are given to me under the health Insurance Portability and Accountability Act of 1996 (**HIPAA**). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day to day healthcare operations of your practice.**

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosure of my protected health information, and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

### Patient Preference Regarding Communication of Health Information

#### Who to Contact

I hereby give permission to Richard Downing, D.D.S., and Staff, to disclose and discuss any information related to my medical/dental conditions(s) to/with the following family members(s), other relatives(s), and/or close personal friends(s):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

( ) I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical/dental condition(s).

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you  
Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No          | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No    |   |
- Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

Dr. Richard C. Downing D.D.S, P.S  
 1626 Olympic Hwy North  
 Shelton WA 98584  
 (360) 426-4712

**PATIENT INFORMATION**

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Date \_\_\_\_\_  
(First) (M.I.) (Last)  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

**RESPONSIBLE PARTY**

Full Legal Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Mailing Address (If different from above) \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_

**INSURANCE**

AS A COURTESY, WE WILL SUBMIT YOUR INSURANCE FORMS IF THE FOLLOWING INFORMATION IS PROVIDED IN COMPLETE DETAIL:

INSURA	INSURANCE COMPANY NAME	ADDITI	ADDITIONAL INSURANCE? IF YES...NAME
Addl	INSURANCE COMPANY ADDRESS:	SUBSCR	INSURANCE COMPANY ADDRESS:
SUBSCR	SUBSCRIBER NAME AND BIRTHDATE:	SUBSCR	SUBSCRIBER NAME AND BIRTHDATE:
SUBCRI	SUBSCRIBER ID NO.:      GROUP NO.:	SUBSCE	SUBSCRIBER ID NO.:      GROUP NO.:
	STATE, ZIP      UNION OR LOCAL:	CITY,	STATE, ZIP      UNION OR LOCAL:
PATIEN ( ) Self (	PATIENT RELATIONSHIP TO SUBSCRIBER: ( ) Self ( ) Spouse ( ) Child ( ) Other	PATIEN ( ) Self (	PATIENT RELATIONSHIP TO SUBSCRIBER: ( ) Self ( ) Spouse ( ) Child ( ) Other
Fdf fdga	If child is 19 years of age or older...	Full tim	College student? School Attending:      Year in School

**RELEASE:** I authorize the dentist or insurance company to release any information required for payment or review of this claim. I hereby authorize my insurance benefits to be paid directly to the dentist. I understand that I am financially responsible for any unpaid balance.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Dr. Richard C. Downing D.D.S, P.S  
1626 Olympic Hwy North  
Shelton WA 98584  
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## Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

In an effort to control the increasing cost of dental care, any or disputes against this office shall be resolved by "binding arbitration". By signing this agreement, the patient agrees with the office of Richard C. Downing, D.D.S., P.S. that any dispute relating to dental or medical care services for any condition, including any services rendered prior to the date of this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement (including associates) shall be resolved by binding arbitration by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including, malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

## Informed Consent Form for General Dental Procedures

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

- Pain, swelling, and discomfort after treatment.
- Infection in need of medication, follow-up procedure or other treatment.
- Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, faces, chin, gums, and tongue along with possible loss of taste.
- Damage to adjacent teeth, restorations or gums.
- Possible deterioration of your condition which may result in tooth loss.
- The need for replacement of restorations, implants or other appliances in the future.
- An altered bite in need of adjustment.
- Possible injury to the jaw and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
- A root tip, fragment or piece of instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
- Jaw fracture.
- If upper teeth are treated, there is a chance of sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
- Allergic reaction to anesthetic or medication.
- Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential risks, and complications of recommended treatment with your dentists. Be certain of all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

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*PATIENT SIGNATURE*                      *DATE*

---

*WITNESS*                                      *DATE*

---

*PRINT PATIENT NAME*

---

*PARENT/LEGAL GUARDIAN*                      *DATE*

Dr. Richard C. Downing D.D.S, P.S  
 1626 Olympic Hwy North  
 Shelton WA 98584  
 (360) 426-4712

**PATIENT INFORMATION**

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Date \_\_\_\_\_  
(First) (M.I.) (Last)  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

**RESPONSIBLE PARTY**

Full Legal Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Mailing Address (If different from above) \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
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INSURANCE COMPANY NAME	ADDITIONAL INSURANCE? IF YES...NAME
INSURANCE COMPANY ADDRESS:	INSURANCE COMPANY ADDRESS:
SUBSCRIBER NAME AND BIRTHDATE:	SUBSCRIBER NAME AND BIRTHDATE:
SUBSCRIBER ID NO.:      GROUP NO.:	SUBSCRIBER ID NO.:      GROUP NO.:
STATE, ZIP                  UNION OR LOCAL:	STATE, ZIP                  UNION OR LOCAL:
PATIENT RELATIONSHIP TO SUBSCRIBER: ( ) Self ( ) Spouse ( ) Child ( ) Other	PATIENT RELATIONSHIP TO SUBSCRIBER: ( ) Self ( ) Spouse ( ) Child ( ) Other
If child is 19 years of age or older...	College student? School Attending:      Year in School

**RELEASE:** I authorize the dentist or insurance company to release any information required for payment or review of this claim. I hereby authorize my insurance benefits to be paid directly to the dentist. I understand that I am financially responsible for any unpaid balance.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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